

CARRIERS' REQUEST FOR OCCUPATIONAL LUNG CENTER EXAMINATION

Only medical information received by the Insurance Commission at least 10 days prior to the examination date will be considered during the examination.

CLAIMANT INFORMATION		
1.	Claimant Name:	
	First N	ame Middle Name or Initial Last Name Generation
2. Claimant Address:		Street, City, State, Zip
•	Claimant Phone #: ()	4. Claimant SSN:
э.	Claimant Frione #.	Include Area Code
5.	Carrier's Claim ID #:	6. Date of Last Exposure with Most Recent Employer:
REASON FOR LUNG CENTER EXAMINATION		
7.	7. Please mark application reason stated below:	
	New Claim Filing	
	Submit the following information for every claim on file under the claimant's SSN:	
	(1) Non-medical Decision (Required)	
	(2) Employee's Report of Occupational Pneumoconiosis (Required)	
	(3) Physician's Report of Occupational Pneumoconiosis (Required)(4) Physician's International Labor Organization (ILO) Form (Required)	
		ccupational Pneumoconiosis (When Available)
	(6) Adjudicated Awards and Compensability Decisions (if applicable)(Final Order) (Required)	
	(7) Previous Occupational Pneumoconiosis Board Findings (Required)	
	Claim Poonening	
	Claim Reopening Submit the following information for every claim on file under the claimant's SSN:	
	(1) Request for Reopening	
	(2) Reopening Decision (Re	quired)
		ded with Reopening Request (Required)
		I Compensability Decisions(if applicable) (Final Order) (Required) Pneumoconiosis Board Findings (if applicable) (Required)
	(5) Frevious Occupational i	Theuritocorilosis Board Filidings (ii applicable) (Required)
	Requested Due to Outcome of Litigation	
	Submit the following information for every claim on file under the claimant's SSN:	
		on from Office of Judges, Board of Review or Supreme Court (Required)
		Compensability Decisions (if applicable) (Final Order) (Required) Pneumoconiosis Board Findings (if applicable) (Required)
	(b) 1 Tevious Codupational I	The arrived models and a mainings (in applicable) (required)
	Fatal Dependent Benefits	
		for every claim on file under the claimant's SSN:
	(1) Non-Medical Decision (
	(2) Application for Depende (3) Death Certificate (Requi	
	(4) Autopsy Report (If Autop	
	(5) Pathology Reports (Who	
		on - X-Rays and X-Ray Reports (Required) Do Not Send Digital X-Ray Recorded on CD
		d Compensability Decisions (if applicable) (Final Order) (Required) Pneumoconiosis Board Findings (if applicable) (Required)
CA	ARRIER AND CONTACT INFORMATI	
8.	Carrier Name:	
	Carrior Hamor	
9.	Contact Person's Name:	
10.	Contact Person's Phone Number	
10.	Contact reison's Filone number	
11.	Contact Person's Email Address:	
12.	Contact Person's USPS Address:	
	Contact Person's USPS Address:	
		Street, City, State, Zip
13.	Contact i ersons orginature.	
14.	Data Signad:	